STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505010	A. BUILDING _____ B. WING _____	C 08/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLAGE	206 SOUTH TENTH AVENUE YAKIMA, WA 98902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This report is the result of an unannounced Abbreviated Survey conducted at Garden Village on 8/05/13, 8/28/13, 8/29/13, and 8/30/13. A sample of 12 residents was selected from a census of 96. The sample included 11 current residents and the record of 1 former and/or discharged resident.

The following were complaints investigated as part of this survey:

#2834442
#2834621
#2841902
#2848697
#2849039
#2850935

Received
Yakima RCS
SEP 27 2013

The survey was conducted by:

[redacted], R.N.
R.N.

The survey team was from:

Department of Social & Health Services
Aging & Long-Term Support Administration
Division of Residential Care Services, District 1, Unit C
3611 River Road, Suite 200
Yakima, WA 98902

Telephone: (509) 225-2800
Fax: (509) 574-5597

Our unannounced, complaint investigation was completed on August 30, 2013. The survey process serves as a guide to "measure" the quality of our services. However the final decision of the quality of our services rests with **you:** our resident, family, doctor and friend of Garden Village.

Thank you for your continued interest in Garden Village. As you review this survey report and have any questions about any aspect of it please do not hesitate to ask for assistance.

[redacted], Administrator

Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also **not** to be construed as an admission of interest against the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

Accordingly, the Facility has prepared and submitted this Plan of Correction solely because of the requirements under state and federal law that mandate submission of a

Plan of Correction within ten (10) calendar days of receipt of the survey report as a

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	9/27/2013

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1	F 000	condition to participate in the Title 18 and Title 19 programs.	
	9/11/13 Residential Care Services / Date		The submission of the Plan of Correction within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure facility staff performed a timely nursing assessment post injury. Deficient practice was identified for 1 of 4 sampled residents (#1) with injuries sustained during staff handling and was not assessed after the injury thus delaying diagnosis and treatment. Staff Member A, a nursing assistant (NA), pushed Resident #1's wheelchair the resident's foot fell down and was twisted under the wheelchair resulting in a right foot fracture. Although reported to Staff Member B, a licensed nurse (LN), the injury site was not assessed for approximately four hours by a LN on the next shift. Findings include but were not limited to: Resident #1: Review of the medical record revealed the resident had multiple diagnoses including arthritis and dementia.	F 309	**F-309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** Resident was assessed and medical attention initiated. 6/21/13 Reviewed incident reports for past 30 days and found no other lack of timely assessments. 9/20/13 LN#B counseled by Nursing Administration that they must notify the charge nurse of any incident/injury so timely assessments can take place. 8/30/13 Nursing Department inserviced by Nursing Administration regarding prompt assessments and communication. 9/25/13 Policy reviewed and clarified. 9/20/13	

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F 309	Continued From page 2 According to the 6/23/13 facility investigative review/conclusion of the 6/21/13 occurrence, after lunch a NA (Staff Member A) was pushing Resident #1 in her wheelchair and the resident's (right) foot got caught and bent back under the wheelchair. The Case Manager (LN) was not notified but the Medication LN (Staff Member B) was notified of the incident and pain medication was requested for the resident. At 6:00 p.m. the resident was found to have a very painful ankle foot and toes. A 6/21/13 nursing entry, by Staff Member C, an evening shift LN, documented that at 6:00 p.m. the resident was "found to have a very painful ankle, foot & toes of the right lower extremity upon movement." The resident's entire foot was swollen and her great toe was dark purple. Results of the 6/21/13 x-ray revealed a possible acute displaced fracture of the navicular (a bone in the foot), diffuse swelling in the right lower leg and ankle, and osteopenia (a lack of bone). Further CT scanning was recommended. A 6/21/13 physician's order included the use of a walking boot or an ace wrap on the right foot to stabilize the bones. Staff Member A, a NA, interviewed on 8/30/13 at approximately 11:25 a.m. stated she did not typically work with the resident. On 6/21/13 at approximately 1:30 p.m. she moved the resident from the dining room. Reportedly, on 6/21/13 somehow Resident #1's foot went underneath the wheelchair and bent back as she was transporting the resident. The resident screamed out. Staff Member A wheeled the resident to her bedroom and left her for another caregiver(s) to assist her into bed.	F 309	Nursing Administration will do random audits of incident for 30 days and report findings to QA committee.	ongoing

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F 309	Continued From page 3 On 8/28/13 at approximately 2:45 p.m. Staff Member D, a NA, stated on 6/21/13 she heard the resident scream out and saw her leg go back (under the wheelchair). Staff Member D was in the resident's room later to check on her and she noticed the resident was having pain in her leg with movement. She reported the incident to Staff Member B and requested pain medication for the resident. Review of the medical record did not reveal any nursing entry related to the incident with resident injury that occurred on the day shift or any associated assessment. The entry/assessment was entered on 6/21/13 at 6:00 p.m. on the next shift. When interviewed on 8/28/13 at approximately 3:05 p.m., Staff Member B, the day shift Medication LN on 6/21/13 recalled she had received a report from a NA that Resident #1 had caught her leg under her wheelchair and she was requesting pain medication for the resident. The resident was provided pain medication but Staff Member B did not assess the resident's foot. She thought the Charge Nurse had received a report and would have assessed the foot. Staff Member B found out later that the foot was not assessed until the evening shift. Following a report of the incident, Staff Member B failed to assess the injury timely despite administration of medication. The resident experienced a fracture in her right foot and pain as a result of the injury.	F 309		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	Continued From page 4	F 323		

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to provide necessary supervision to: A) to ensure resident care was provided in accordance with the plan of care, including the use of necessary equipment to maintain resident safety; deficient practice was identified for 1 of 4 sampled residents (#1) with injuries sustained during staff handling. Resident #1 did not have bilateral leg rests/foot pedals in place on her wheelchair despite a directive for their use. As Staff Member A, a nursing assistant (NA), pushed Resident #1's wheelchair the resident's foot fell down and was twisted under the wheelchair resulting in a right foot fracture. Additionally, the facility failed to supervise to: B) prevent recurrence of resident to resident aggression for 2 of 4 sampled residents (#10 & #12) involved in resident to resident altercations and C) discover a resident was missing and initiate the policy to search/locate the resident for 1 of 2 sampled residents (#5) with elopements. Failure to adequately supervise the residents placed them and/or others at risk for injury or harm. Findings include:

A. Prevent unnecessary injury and pain

Resident #1: Review of the medical record

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revealed the resident had multiple diagnoses including arthritis and dementia. According to the plan of care, Resident #1 used a wheelchair for transportation and staff was to take her to all destinations as she no longer walked. "Make sure my leg rests (sic) are on my wheelchair & I am completely back in the seat."

A 6/21/13 nursing entry, by Staff Member C, an evening shift LN, documented that at 6:00 p.m. the resident was "found to have a very painful ankle, foot & toes of the right lower extremity upon movement." The resident's entire foot was swollen and her great toe was dark purple. Results of the 6/21/13 x-ray revealed a possible acute displaced fracture of the navicular (a bone in the foot), diffuse swelling in the right lower leg and ankle, and osteopenia (a lack of bone). Further CT scanning was recommended. A 6/21/13 physician's order included the use of a walking boot or an ace wrap on the right foot to stabilize the bones.

According to the 6/23/13 facility investigative review/conclusion of the 6/21/13 occurrence, after lunch a NA (Staff Member A) was pushing Resident #1 in her wheelchair and the resident's (right) foot got caught and bent back under the wheelchair. At the time, the resident only had one foot pedal in place on her wheelchair. According to the Staff Member A the other foot pedal could not be found. Another nursing assistant (Staff Member D) was following behind and reported Staff Member A was going a little too fast and the wheelchair was not tilted back. The Case Manager (LN) was not notified but the Medication LN (Staff Member B) was notified of the incident and pain medication was requested for the resident. At 6:00 p.m. the resident was

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found to have a very painful ankle foot and toes. An additional pain medication was requested from the physician. The wheelchair was replaced.

Review of the June 2013 medication administration record (MAR) revealed the resident was provided Tylenol for foot pain on 6/21/13, 6/23/13, and on 6/25/13. The June 2013 MAR also documented on 6/26/13 at 4:45 p.m. the resident was experiencing 10 out of 10 right foot pain (ten being the highest rating), she was crying, and received another type of pain medication. The resident also received pain medication on 7/01/13 per the July 2013 MAR.

On 6/28/13 a follow-up x-ray was obtained of Resident #1's right foot. A (bone) chip was noted in the right foot. It was difficult to determine whether the chip had come from the navicular bone or the adjacent bone. Soft tissue swelling was evident.

A resident observation on 8/28/13 at approximately 12:15 p.m. noted the resident was seated in the dining room in her wheelchair with two leg rests in place.

When interviewed on 8/30/13 at approximately 12:20 p.m., Staff Member F, a NA who frequently cared for Resident #1, recalled that one of the leg rests on the wheelchair wouldn't lock properly and would swing to the side but he continued to place the leg rest. Staff Member F recalled about a week before the incident, the problem with the wheelchair leg rest had been reported and they were awaiting repair. Staff continued to use the wheelchair despite the problem with the leg rest/foot pedal.

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F 323	Continued From page 7 Staff Member A, a NA, interviewed on 8/30/13 at approximately 11:25 a.m. stated she did not typically work with the resident. On 6/21/13 at approximately 1:30 p.m. she moved the resident from the dining room. The resident did not have one of the foot pedals (leg rest). She stated there had just been one foot pedal for a while. Reportedly, on 6/21/13 somehow Resident #1's foot went underneath the wheelchair and bent back as she was transporting the resident. The resident screamed out. Staff Member A wheeled the resident to her bedroom and left her for another caregiver(s) to assist her into bed. On 8/28/13 at approximately 2:45 p.m. Staff Member D, a NA, stated on 6/21/13 she was behind Staff Member A as she exited the dining with Resident #1. She observed that Resident #1 was upright in her wheelchair moving fast. Staff Member D heard the resident scream out and saw her leg go back (under the wheelchair). Staff Member D was in the resident's room later to check on her and she noticed the resident was having pain in her leg with movement. REFER TO F-309. Despite ongoing problems with the wheelchair leg rest/foot pedal, facility staff continued to use the wheelchair. Failure to support the resident's leg/foot adequately placed the resident at risk for injury and on 6/21/13 the injury occurred. B. Resident to resident altercations: Resident #10: Review of the medical record revealed the resident had multiple diagnoses including dementia, [redacted] and expressive aphasia (difficult speech and	F 323	**F-323 483.25(h) FREE OF ACCIDENT HAZARDS/ SUPERVISION/DEVICES** A. Resident #1 w/c repaired prior to surveyor's visit. Policy regarding malfunctioning wheelchairs updated by Nursing Administration. Nursing Department inserviced by DNS to review procedure for broken equipment. Audit of all w/c for appropriate foot pedals completed by rehab and reported to DNS for QA. Random audits of foot pedals will take place by Rehab under direction of DNS for 30 days and reported to QA.	9/20/13 9/25/13 9/20/13 ongoing

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expression of his thoughts). According to the plan of care, the resident frequently walked without staff assistance to the point of fatigue.

A social service assessment, dated 7/09/13, noted the resident responded to internal stimuli ([redacted]) a majority of the day and occasionally demonstrated aggressive behaviors. He was noted to be moderately impaired for decision making.

Review of facility investigative documentation noted the resident had been involved in multiple resident to resident altercations typically without any provocation.

According to an 8/01/13 nursing entry and facility investigative documentation, Resident #10 approached Resident #11 in the dining room stating he thought she had stolen a tool from him. Resident #10 struck Resident #11 in the face twice causing a red mark on her cheek and a small cut on the inside of her lip. Resident #10 received additional medication and remained in his room thereafter.

Per an 8/15/13 7:00 a.m. nursing entry Resident #10 had pushed another resident (Resident #9) hard enough for her to lose her balance and fall on the floor. Resident #10 was redirected to his bedroom and given extra medication to address his agitation as well as his routine medications. The resident did not stay in his room.

An 8/15/13 7:30 a.m. nursing entry documented Resident #10 entered the dining room and pushed another resident (Resident #12) hard enough for her to fall to the floor. The investigative document noted Resident #12

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F 323	Continued From page 9 sustained an abrasion near her left eye/cheek and a right knee abrasion. One on one supervision was initiated after the second incident. Resident #10 was sent to the hospital for a psychiatric evaluation. Observation of Resident #10 on 8/28/13 at 1:35 p.m. noted he was walking up and down the hallway with a blank expression on his face and did not respond verbally when addressed. When interviewed on 8/30/13 at approximately 4:45 p.m. Administrative Staff Member E stated there had been no enhanced supervision for Resident #10 following his first episode of aggression on 8/15/13. He was sent to the hospital after the second incident. Despite facility knowledge of Resident #10's demonstrated aggressive behaviors toward Resident #9 on 8/15/13, and other occasions, there was no evidence of enhanced staff supervision to protect other residents. Resident #10 pushed another resident resulting in some superficial injuries and distress for Resident #12. C: Elopement: Resident #5: Review of the medical record revealed the resident had multiple diagnoses including poly-substance abuse, cirrhosis of the liver, and multiple mental health conditions. The resident was on a fluid restriction. He received multiple psychoactive medications for management of his mental health issues. A social service assessment, dated 6/20/13, documented the resident's decision making was moderately impaired and his judgment and insight	F 323	B. LN was counseled by DNS for not initiating enhanced supervision after incident #1. Instituted SRA until resident #10 detained to psych unit by MHP's Policy for Catastrophic Behavior reviewed by DNS. No changes made. LN's inserviced by Nursing Administration related to their responsibility to provide enhanced supervision to protect other residents. QA LN will monitor incident reports for compliance and report findings to DNS and QA committee.	8/15/13 9/9/13 8/15/13 9/25/13 ongoing

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were very poor with an illogical flow of ideas and delusions.

The resident's plan of care noted he transferred and ambulated independently at times and at other times he required assistance with walking and even used a wheelchair on occasion. The plan of care also documented, "I need help w/ (with) key pads & do not use my call light."

According to a nursing entry on 7/04/13 at 11:00 p.m., the resident left the building without permission. Another facility resident was on an outing and when he returned he stated Resident #5 was at a local grocery store bumming cigarettes. Staff drove to the grocery store and picked up Resident #5. Upon his return Resident #5 was intoxicated and stated he had a 24 ounce Old English (beer) and a cigarette.

The facility investigation, dated 7/04/13, identified the resident was last seen by staff at 7:30 p.m. when he received a snack. No one saw him leave the building and staff were unaware he was missing. The resident was returned to the building at 10:30 p.m. (3 hours later) after staff were notified by another resident. No injuries were identified. The resident went to bed but didn't stay there very long. Resident #5 got up and became verbally and physically aggressive with a LN. One on one staff supervision was then initiated. The resident asked another resident to assist him over the facility fence. The mental health professionals were contacted and the resident was sent to the hospital for an evaluation.

Observations on 8/28/13 at approximately 3:10 p.m. revealed Resident #5 interrupted a

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F 323	Continued From page 11 conversation with the Investigator and Staff Member B multiple times requesting assistance to ensure he was able to see the psychiatrist due to concerns about his medications and possible side effects. Despite a suggestion about who to talk with, he continued to reapproach Staff Member B with the same request. On 8/28/13 at approximately 3:55 p.m., Staff Member G, an evening shift Nursing Assistant (NA) stated that on 7/04/13 she and Staff Member H, a NA, teamed together to care for a group of assigned residents including Resident #5. Staff Member G recalled seeing Resident #5 sometime between 7:00 p.m.-7:30 p.m. at the smoke break but did not see him after that. Typically, the resident walked around, played cards, went outside, or went to the lobby but was generally in bed around 9:00 p.m. The resident was pretty independent but needed caregiver assistance to remove his leg wraps in the evening. When interviewed on 8/28/13 at approximately 4:00 p.m., Staff Member H recalled the resident was talking about beer in the dining room on 7/04/13 but she didn't think anything about it. They were very busy caring for other residents that evening and heard about the resident's elopement the next day after returning to work. On 8/28/13 at approximately 11:30 a.m. Staff Member E stated staff were supposed to check on residents every two hours. Resident #5 was last seen three hours earlier on 7/04/13 and staff were unaware he was missing. On 7/04/13 Resident #5 exited the building without staff knowledge. Although the resident	F 323	C. Reviewed elopement with Social Workers and LN's. This resident very independent, likes outside walks. Policy for elopement reviewed by SSD. Added addendum related to residents who desire outings and an assessment tool for structured vs. independent walks by Social Service Director. SSD will monitor compliance and safety awareness for 30 days and PRN and report findings to QA committee. Resident has had successful outings since incident of 7/4/13 with excellent safety record. Inservice with Nursing Department to review make sure no one tries to go out door when visitors or staff go in/out.	7/5/13 9/25/13 ongoing 9/25/13 9/25/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505010	A. BUILDING _____ B. WING _____	C 08/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLAGE	206 SOUTH TENTH AVENUE YAKIMA, WA 98902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 12 was relatively independent with his activities of daily living, he required staff assistance during the evening shift for removal of leg wraps and for medication administration at bedtime. Caregivers failed to check on his whereabouts/provide supervision and were unaware he was missing. Meanwhile, the resident was in the community for approximately three hours (much of the time in the dark) panhandling and drinking alcohol, an activity that posed some risks with his [redacted] medications and his health conditions. Resident #5 required supervision within a structured environment due to mental health conditions and associated behaviors.	F 323		